Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Hearing Aids & Services

Billing Instructions

September 2000

About this publication

This publication supersedes all previous Hearing Aids & Services Program Billing Instructions and Numbered Memorandas 97-72, 99-38 MAA, and 00-47 MAA.

You may request a copy of the law relating to Hearing and Speech (18.35 RCW) from:

Washington State Department of Health
Board of Hearing and Speech
PO Box 47869
Olympia, WA 98504-7869

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
September 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

Table of Contents

Table of Contents (cont.)

Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2))

.

Where do I call for information on becoming a DSHS provider?

Provider Enrollment Unit
(800) 562-6188 **Select Option 1** -or-
(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

Electronic billing?

Write/call:
Electronic Billing Unit
PO Box 45564
Olympia, WA 98504-5564
(360) 753-0318

Where do I call/write if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, Healthy Options, or to request billing instructions?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Division of Client Support
Coordination of Benefits Section
1-800-562-6136

Limitation Extensions

Division of Health Services Quality Support
Quality Fee for Service Section
Limitation Extension
PO Box 45506
Olympia, WA 98504-5506
Telephone (360) 725-1583
Fax (360) 586-2262

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
1-800-562-6188

This is a blank page.

Definitions

This section defines terms and acronyms used in these billing instructions.

Children with Special Health Care Needs (CSHCN) – Children with disabilities or handicapping conditions; chronic illnesses or conditions; health related educational or behavorial problems; or children at risk of developing such disabilities, conditions, illnesses or problems. (WAC 246-710-010)

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Deafness - Complete or partial loss of ability to hear.

Department - The state Department of Social and Health Services. (WAC 388-500-0005)

Digital hearing aids – Hearing aids with a digital signal processor inside that converts analog sound into a digital code that allows for enhanced ability to amplify speech over background noise. *All digital hearing aids are programmable, but not all programmable hearing aids are digital.*

Early and Periodic Screening, Diagnosis, And Treatment (EPSDT) -
Also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the children's health program. (WAC 388-500-0005)

Expedited Prior Authorization (EPA) – A process designed by MAA to eliminate the need for written prior authorization (see definition for “prior authorization”). MAA establishes authorization criteria and identifies these criteria with specific codes. If the provider determines the client meets the criteria, the provider creates the authorization number using the specific MAA-established codes.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

FM Systems – A hearing device that uses a frequency modulated radio signal. FM systems are sometimes referred to as radio frequency (RF) aids.

Health, Department of – The Washington state department responsible for preserving public health, monitoring health care costs, maintaining minimal standards for quality in health care delivery, and generally overseeing and planning the state's activities as they related to the health of its citizenry. (WAC 246-01-001)

Hearing Aid - A device that amplifies sound and which does not discriminate between wanted and unwanted sound, nor rectify sound distortion experienced by most hearing impaired clients.

Limitation Extension – Prior authorization from MAA to exceed the service limits (quantity, frequency, or duration) set in WAC or in MAA's billing instructions.

Local CSHCN Agency – The local health jurisdiction or other agency locally administering the CSHCN program for the county where the client resides in the state of Washington. (WAC 246-710-010)

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable Fee - The maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program [CNP] as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program [MNP] as defined in WAC 388-503-0320. (WAC 388-500-0005)

Medical Assistance Administration (MAA) - The administration within the Department of Social and Health Services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs, with the exception of the certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

OCSHCN - The Department of Health's Office of Children with Special Health Care Needs.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Prior Authorization – MAA and/or Department of Health approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extensions are forms of prior authorization.

Programmable hearing aids – Hearing aids that can be "programmed" digitally by a computer. *All digital hearing aids are programmable, but not all programmable hearing aids are digital.*

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Remittance And Status Report (RA) - A report produced by the Medicaid Management Information System that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
(WAC 388-500-0005)

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

1) The usual and customary charge that you bill the general public for the same services; or
2) If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC)
- Codified rules of the State of Washington.

Hearing Aids Program

About the program

- MAA covers only the hearing aid services listed in this billing instruction, subject to exceptions, restrictions, and limitations as noted.
- MAA evaluates requests for services listed as noncovered or subject to limitations or other restrictions according to the provisions in WAC 388-501-0165.
- MAA reimburses providers at the maximum allowable rates listed in this billing instruction (see Fee Schedule, page 24).

Client Eligibility

Who is eligible?

Clients presenting Medical Assistance IDentification (MAID) cards with one of the following identifiers are eligible for hearing aid services:

MAID Identifier	Medical Program
CNP	Categorically Needy Program
CNP-CHIP	CNP–Children's Health Insurance Program
CNP-QMB	CNP–Qualified Medicare Beneficiary
GAU – No out of state care	General Assistance – Unemployable
General Assistance – No out of state care	ADATSA, ADATSA Medical Only
LCP-MNP (Only for clients through 20 years of age. **See note below.**)	Limited Casualty Program – Medically Needy Program

☞ **Note:** Clients 18 through 20 years of age must either be referred by a screening provider under the Healthy Kids/EPSDT program **or** meet the requirements on page 8.

When a client is referred by a screening provider under the Healthy Kids EPSDT program, include the referring provider number in field 17a on the HCFA-1500 claim form. If no MAA provider number is available, enter the referring provider's name in field 17. Keep referral information in the client's file.

Are hearing aid services covered under MAA's Healthy Options managed care plans?

Hearing aid services are not covered under MAA's Healthy Options managed care plans. Hearing aid equipment and services for clients enrolled in Healthy Options are reimbursed through the fee-for-service system.

Eligibility, coverage and billing guidelines found in this billing instruction also apply to clients enrolled in Healthy Options.

Coverage - Adults

What is covered for adults?

Purchase

MAA covers the **purchase** of one new, non-refurbished hearing aid for an adult client every 5 years if all of the following conditions are met:

- The client must:
  - ✓ Be 18 years of age or older;
  - ✓ Present a MAID card with the appropriate identifier (see Client Eligibility Section, page 6);
  - ✓ Have an average hearing of 50 dBHL or worse in the better ear based on auditory screening by a certified audiologist or licensed hearing instrument fitter/dispenser at 1000, 2000, 3000, and 4000 Hertz (Hz) with effective masking as indicated.
- The client's current hearing aid (if the client has one) is not sufficient for the hearing loss in the better ear.
- The hearing aid must be:
  - ✓ Medically necessary; and
  - ✓ Warranted for one year.

☞ **Note:** Reimbursement for adult hearing aids includes:

- ➢ A prefitting evaluation;
- ➢ An ear mold; and
- ➢ A minimum of three post-fitting consultations.

Repair

MAA covers the **repair** of a hearing aid when the:

- ✓ Initial one-year warranty has expired;
- ✓ Client continues to meet the criteria for eligibility (see page 6) and purchase (see page 8);
- ✓ Cost of repair is less than 50% of the cost of a new hearing aid;
- ✓ Provider has documented the repair and replacement costs; and
- ✓ Repair is warranted for 90 days.

Rental

MAA covers the cost of renting a hearing aid for up to two months while the client's own hearing aid is being repaired. When billing MAA, **use HCPCS[1] code V5050** with modifier **RR**.

Replacement

MAA covers **one replacement hearing aid** (which includes ear mold and/or casing) in a 5-year period when the:

- ✓ Hearing aid is lost or broken beyond repair;
- ✓ Client continues to meet the criteria for eligibility (see page 6) and purchase (see page 8); and
- ✓ Provider has documented the necessity for the replacement in the client's file.

Note: When billing for a one-time, replacement hearing aid within a five-year period, **use modifier RP (replacement)** with the appropriate procedure code. Refer to Fee Schedule, page 24.

MAA covers **replacement of ear molds** as follows:

- ✓ Once a year for soft ear molds; and
- ✓ Once every three years for hard ear molds.

[1] HCPCS – Health Care Finance Administration's Common Procedure Coding System

What is not covered for adults?

MAA does not cover any of the following:

- The purchase of batteries, ear trumpets, or tinnitus maskers;
- Group screenings for hearing loss;
- Hearing aid charges reimbursed by insurance or other payer source;
- Digital hearing aids;
- FM Systems; or
- Programmable hearing aids.

Coverage - Children

Per chapter 388-544 WAC, clients 17 years of age and younger who require hearing aid services must be referred to the Department of Health's Children with Special Health Care Needs (CSHCN) program. The CSHCN coordinator prior authorizes hearing aid equipment and services for MAA-eligible children by verifying medical necessity from information supplied by the provider before the equipment is dispensed. **Prior authorization does not guarantee payment. Eligibility requirements must still be met.** The provider is responsible for following billing instructions in order to receive payment from MAA.

What is covered for children?

Purchase

MAA covers the **purchase** of new, non-refurbished hearing aids for clients if all of the following conditions are met:

- The client must:
  - ✓ Be 17 years of age and younger;
  - ✓ Present a MAID card with a valid identifier (see Client Eligibility Section, page 6); and
  - ✓ Have prior authorization from the child's local Department of Health's (DOH) CSHCN coordinator to receive a hearing aid. (See Authorization Section, page 14.)
- The hearing aid must be:
  - ✓ Medically necessary; and
  - ✓ Warranted for one year.

☞ **Note:** Provider reimbursement for children's hearing aids includes all of the following:

- ➢ A prefitting evaluation;
- ➢ An ear mold for in the ear (ITE) hearing aids; and
- ➢ A minimum of three post-fitting consultations.

Repair

MAA covers the **repair** of a hearing aid when the:

- ✓ Client's local CSHCN coordinator authorizes the repair;
- ✓ Initial one-year warranty period has expired;
- ✓ Client continues to meet the criteria for eligibility (see page 6) and purchase (see page 11);
- ✓ Cost of repair is less than 50% of the cost of a new hearing aid;
- ✓ Provider has documented the repair and replacement costs; and
- ✓ Repair is warranted for 90 days.

Rental

MAA covers the cost of renting a hearing aid while the client's own hearing aid is being repaired when the rental is authorized by the client's local CSHCN coordinator. Bill MAA **using state-unique code 5021V** with modifier **RR**.

Replacement

- MAA covers **replacement of a hearing aid** when the:

  - ✓ Client's local CSHCN coordinator authorizes the replacement;
  - ✓ Client continues to meet the criteria for eligibility (see page 6) and purchase (see page 11);
  - ✓ Hearing aid is lost or broken beyond repair; and
  - ✓ Provider has documented the necessity for the replacement.

- MAA covers **replacement of hard and soft ear molds** when the replacement is authorized by the client's local CSHCN coordinator.

What is not covered for children?

MAA does not cover any of the following:

- Purchase of batteries, ear trumpets, or tinnitus maskers;
- Group screenings except as provided under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program/Healthy Kids under WAC 388-534;
- Computer-aided hearing devices used in school;
- Hearing aid charges reimbursed by insurance or other payer source;
- Digital hearing aids; or
- FM systems or programmable hearing aids when the device is used in school, or when the child's hearing loss is adequately improved with hearing aids.

Authorization

What is prior authorization?

Prior authorization is MAA and/or Department of Health approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization and limitation extensions are forms of prior authorization.**

Prior Authorization for Children

Prior authorization is required for all hearing aid equipment or services for children. The local Children with Special Health Care Needs (CSHCN) coordinator in the county where the client resides (see page 26) authorizes all hearing aid equipment or services for children **except** FM Systems. FM Systems are authorized by the Medical Assistance Administration (MAA) through the Expedited Prior Authorization (EPA) process.

Requesting prior authorization from the client's local CSHCN coordinator

Prior to dispensing equipment and/or related services, providers must send a completed HCFA-1500 claim form, including all backup documentation, to the local CSHCN coordinator (see page 26). Each requested item or service must be identified using the appropriate procedure code.

1. The CSHCN coordinator reviews the request to verify that required otological and audiological examinations have been provided and certifies the medical necessity of requested equipment or service.

2. If results of the examinations show the criteria have been met, the CSHCN coordinator puts the CSHCN stamp and his or her signature in *field 23* of the HCFA-1500 claim form.

3. The CSHCN Coordinator approves by initialing each authorized line item (equipment or service) in *field 24K* of the HCFA-1500 claim form. If the CSHCN coordinator does not initial a line item, MAA will deny payment for that line item.

4. The CSHCN coordinator returns the form to the provider, who may proceed to dispense the equipment and/or services authorized by the CSHCN coordinator. A copy of the list of authorized equipment and/or services will be kept by the CSHCN coordinator.

5. After the hearing aid equipment has been dispensed or the approved service provided, the provider bills MAA by submitting the HCFA-1500 claim form stamped, signed, and initialed by the local CSHCN coordinator. (See "Important Contacts" for billing address.) The provider is responsible for following MAA billing instructions to receive payment.

Prior Authorization for Adults

Prior authorization is not required for adults.

What are Limitation Extensions?

Limitation extensions are cases when a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instructions and Washington Administration Code (WAC).

Note: Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups receive all services.

For example: Hearing aids are not covered under the Medically Indigent Program (MIP).

How do I request a limitation extension?

There are two ways to request a limitation extension:

1) Providers may be able to obtain authorization for these limitation extensions using an expedited prior authorization number. These EPA numbers will be subject to post payment review as in any other authorization process. (See "What is Expedited Prior Authorization," page 17.)

2) In cases where the client's situation does not meet the EPA criteria for a limitation extension, but the provider still feels that additional services are medically necessary, the provider must request MAA approval in writing.

The request must state the following in writing:

1. The name and PIC of the client;
2. The provider's name, provider number and FAX number;
3. Additional service(s) requested;
4. Copy of current audiogram for both ears and the date the last hearing aid(s) were dispensed;
5. The primary diagnosis with CPT or state assigned code of the requested service; and
6. Clinical justification for additional services.

Send your written request for a limitation extension to:

Division of Health Services Quality Support
Quality Fee for Service Section
Limitation Extension
PO Box 45506
Olympia, WA 98504-5506
Telephone (360) 725-1583
Fax (360) 586-2262

What is Expedited Prior Authorization?

Expedited prior authorization (EPA) numbers are designed to eliminate the need for written authorization. MAA establishes authorization criteria and identifies these criteria with specific codes, enabling providers to create an "EPA" number using those codes.

To bill MAA for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **form a 9-digit EPA number.** The first six digits of the EPA number must be **870000**. The last 3 digits must be the code assigned to the diagnostic condition, procedure, or service that meets the EPA criteria (see pages 18 and 19 for codes). Enter the EPA number on the billing form in *field 23* when billing for adults and *field 19* when billing for children, or in the *Authorization* or *Comments* field when billing electronically. **(Do not put the EPA # in field 23 when billing for children because the CHSCN Coordinators use that field for their signature stamp.)**

Example: The 9-digit authorization number for an exam for a 25 year old client whose average hearing is 40 dBHL in the 1000-4000 Hertz (Hz) and is legally blind would be **870000600.**

870000 = first six digits of all expedited prior authorization numbers
600 = last three digits of an EPA number indicating the service and which criteria the case meets.

- MAA denies claims submitted without the appropriate diagnosis, procedure code, or service as indicated by the last three digits of the EPA number.

- The billing provider must document in the client's file how expedited prior authorization criteria was met, and make this information available to MAA on request.

EPA – Limitation Extension for Adults

Hearing Aids - Adults

State-Unique Codes: 5047V, 5048V, 5049V, 5050V

600 **Initial Hearing Aid** for clients 18 years of age and older, when auditory screening shows an average hearing of 50 dBHL or worse in one ear at 1000, 2000, 3000 and 4000 Hz and has one or more of the following documented in the client's medical records:

1. Inability to hear has caused difficulty with job performance;
2. Inability to hear has caused difficulty in functioning in the school environment; or
3. Client is legally blind.

601 **Second Hearing Aid** for clients 18 years of age and older, who have tried to adapt with one hearing aid for a period of 6 months, whose auditory screening shows an average hearing of 50 dBHL or worse in both ears at 1000, 2000, 3000, and 4000 Hz and has one or more of the following documented in the client's records:

1. Inability to hear has caused difficulty with job performance;
2. Inability to hear has caused difficulty in functioning in the school environment; or
3. Client is legally blind.

EPA – Limitation Extension for Children

Programmable Hearing Aids - Children
State-Unique Codes: 5008V and 5009V

605 **Programmable Hearing Aid** for a client 2-17 years of age, when prescribed by an audiologist and **at least one** of the following criteria is documented in the client's medical records:

1. The hearing loss pattern varies significantly or fluctuates from frequency to frequency (more than a 20 dBHL difference between octave bands).
2. Client has progressive hearing loss.
3. Client has developmental delays and is unable to give reliable test responses.
4. Client has physical or developmental disabilities and cannot adjust controls independently.
5. Background noise, discrimination problems, or recruitment are particularly problematic in the client.
6. Before and after testing, the client has demonstrated the effectiveness of a programmable aid(s) over regular hearing aid(s).

FM System - Children
State-Unique Code: 5011V

606 **FM System** for clients 2-17 years of age with the following documented in the client's records:

1. Completed comprehensive clinical testing with and without an FM system **or** proven successful use of an FM system in school; **and**
2. A diagnosis of apraxia, severe bilateral hearing loss not adequately benefited with hearing aids, auditory neuropathy, other "central" processing problems, **or** multiple handicaps; **and**
3. Average hearing of 50 dBHL or worse at 1000, 2000, 3000, and 4000 Hz.; **and**
4. Prescribed by an audiologist.

Billing

What is the time limit for billing? (Refer to WAC 388-502-0150)

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[2] certification criteria.

  ✓ MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:

  - DSHS certification of a client for a retroactive[3] period; or
  - The provider proves to MAA's satisfaction that there are other extenuating circumstances.

  ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

[2] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) for a covered service received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[3] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- **Resubmitted Claims**

  ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:
  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov/ or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept in the client's file?

(Refer to WAC 388-502-0020)

Specific to the Hearing Aids & Services Program, documentation of all hearing tests and results must be kept in the complete client's chart and record.

This includes, but is not limited to, the following tests:

- Audiogram results/graphs/tracings (including air conduction and bone conduction comparisons);
- Basic or simple hearing tests or screening, such as is done in many schools;
- Tympanogram;
- Auditory Brainstem Response (ABR); and
- Elecronystagmogram (ENG) (not a hearing test but a special test of inner ear balance).

In general, enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.

Fee Schedule

Hearing Aids for Adults

Services and/or items for adults must meet program requirements..

Effective 7/1/02

State-Unique Procedure Code	Description	Modifier	Maximum Allowable
5047V	In the Ear (ITE)	RT, LT, or RP	$459.87
5049V	Behind the Ear (BTE)	RT, LT, or RP	459.87
5051V	Assistive Listening Device (taxable) For adults who are unable to use a regular hearing aid or do not want a regular hearing aid, but need amplification. Same criteria as other adult hearing aids.	RT, LT, or RP	141.57
*V5050	Hearing Aid, Monaural (monthly rental only) Payable only when client's hearing aid is being repaired. Payment not to exceed 2 months.	RR	31.72
5002V	Hearing Aid Casing (replacement only) Allowed no more than once in 5 years.	RP	80.86
5003V	Hearing Aid Ear Mold (replacement only) Allowed no more than once in 3 years.	RP	36.25
5004V	Repairs (includes parts and labor)		79.31

Please bill your usual and customary charge.
Payment will be the lesser of billed charge or the maximum allowable fee.

* HCPCS procedure code.

Modifiers

LT = Left RT = Right RP = Replacement RR = Rental

Hearing Aids for Children

Children's hearing aid equipment and services
REQUIRE authorization from the client's local CSHCN coordinator.

Effective 7/1/02

State-Unique Procedure Code	Description	Modifier	Maximum Allowable
5052V	Monaural In the Ear (ITE)	RT, LT, or RP	$463.84
5054V	Binaural ITE		881.72
5056V	Monaural Behind the Ear (BTE) w/o Audio Input	RT, LT, or RP	493.94
5058V	Binaural BTE w/o Audio Input		938.69
5060V	Monaural BTE with Audio Input	RT, LT, or RP	505.84
5062V	Binaural BTE with Audio Input		960.68
5064V	Monaural Bone Conduction Aid	RT, LT, or RP	523.82
5066V	Monaural On the Body Aid	RT, LT, or RP	523.82
5068V	Binaural On the Body Aid		942.79
5021V	Rental per month (child)	RR	38.88
5040V	Ear Mold for BTE Aid		38.88
5042V	Replacement ITE Ear Mold	RP	83.31
5044V	Recasing, ITE or BTE Aid (includes parts and labor)	RP	83.31
5046V	Repairs (includes parts and labor)		83.31

The following procedure codes are covered only when approved as a limitation extension.

5008V	Binaural Programmable		1,987.24
5009V	Monaural Programmable		1,070.25
5011V	FM System		2,277.04

Please bill your usual and customary charge.
Payment will be the lesser of billed charge or the maximum allowable fee.

Modifiers

LT = Left RT = Right RP = Replacement RR = Rental

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN) LOCAL AGENCY COORDINATORS AND SUPPORT STAFF

(Street addresses in parenthesis are only used for package deliveries by carriers other than the U.S. Postal Service.)

County	Contact/Address	Communications
Adams County Health District	108 West Main Ritzville, Washington 99169	(509) 659-3317 ◆ FAX (509) 659-4109
Asotin County Health District	431 Elm Street Clarkston, Washington 99403	(509) 758-3344/3345 ◆ FAX (509) 758-8454
Benton-Franklin Health District	800 West Canal Drive Kennewick, Washington 99336	(509) 586-0207, ext. 236 ◆ FAX (509) 585-1525
Bremerton-Kitsap County Health District	109 Austin Drive Bremerton, Washington 98312	(360) 478-5235 ◆ FAX (360) 478-5298
Chelan-Douglas Health District	200 Valley Mall Parkway East Wenatchee, Washington 98802 *For mailing address, use the following:* PO Box 429 Wenatchee, Washington 98807	(509) 886-6400 ◆ FAX (509) 886-6478
Clallam County Department of Health & Human Services	223 East Fourth Street (PO Box 863) Port Angeles, Washington 98362-0149	(360) 417-2439 ◆ FAX (360) 417-2519
Columbia County Health District	221 East Washington, Suite 101PH Dayton, Washington 99328	(509) 382-2181 ◆ FAX (509) 382-2942
Cowlitz County Health Department	600 Broadway, Third Floor Longview, Washington 98632 *For mailing address, use the following:* 207 Fourth Avenue North Kelso, Washington 98626-4124	(360) 414-5599 ◆ FAX (360) 425-7531
Garfield County Health District	Post Office Box 130 (10th & Columbia) Pomeroy, Washington 99347	(509) 843-3412 ◆ FAX (509) 843-1935
Grant County Health District	1021 West Broadway Moses Lake, WA 98837	(509) 766-7960 ◆ FAX (509) 766-6519
Grays Harbor Health Department	2109 Sumner Avenue Aberdeen, Washington 98520	(360) 532-8631 ◆ FAX (360) 533-6272

** Indicates Regional Representative

◆ FAX or Internet not located in agency office.

County	Contact/Address	Communications
Island County Health Department	Post Office Box 5000 (410 North Main Street) Coupeville, Washington 98239	(360) 679-7351 ◆ FAX (360) 679-7347
Jefferson County Health and Human Services	615 Sheridan, Castlehill Center Port Townsend, Washington 98368	(360) 385-9400 ◆ FAX (360) 385-9401
Kittitas County Health Department	507 Nanum Street, Room 102 Ellensburg, Washington 98926	(509) 962-7635 ◆ FAX (509) 962-7581
Klickitat County Health Department	Post Office Box 159 (170 NW Lincoln) White Salmon, Washington 98672	White Salmon 1-888-267-1199 ◆ FAX (509) 493-4025 Goldendale 1-888-291-3521
Lewis County Health Department	360 N.W. North Street M.S. HSD03 Chehalis, Washington 98532	(360) 740-1383 ◆ FAX (360) 621-1472
Lincoln County Public Health Coalition	90 Nicholls Street Davenport, Washington 99122	(509) 725-1000, ext. 26 ◆FAX (509) 725-1014
Mason County Health Department	303 North Fourth Street Shelton, Washington 98584	(360) 427-9670, Ext. 408 ◆ FAX (360) 427-7787
N.E. Tri-County Health District *Pend Oreille County*	Post Office Box 490 (230 South Garden) Newport, Washington 99156	(509) 447-3131 ◆ FAX (509) 447-5644
N.E. Tri-County Health District *Stevens County*	Post Office Box 270 (240 East Dominion Street) Colville, Washington 99114	(509) 684-5048 ◆ FAX (509) 684-1002
N.E. Tri-County Health District *Ferry County*	Post Office Box 584 (470 North Clark Ave, Suites 11 & 12) Republic, Washington 99166	(509) 775-3111 ◆ FAX (509) 775-2858
Okanogan County Health District	Post Office Box 231 (1234 South Second) Okanogan, Washington 98840	(509) 422-7140 1-800-222-6410 ◆ FAX (509) 422-7384
Pacific County Health Department	Post Office Box 26 (1216 W Robert Bush Drive) South Bend, Washington 98586	(360) 875-9343 ◆ FAX (360) 875-9323
San Juan County Health Department	Post Office Box 607 (145 Rhone Street) Friday Harbor, Washington 98250-0607	(360) 378-4474 ◆ FAX (360) 378-7036
Public Health – Seattle & King County	999 Third Avenue (MS: FIC-PH-0905) Seattle, Washington 98104-4039	(206) 296-4610 ◆ FAX (206) 296-4679

** Indicates Regional Representative

◆ FAX or Internet not located in agency office.

County	Contact/Address	Communications
Skagit County Health Department	700 South Second, Room 301 Mount Vernon, Washington 98273	(360) 336-9380 ◆ FAX (360) 336-9401
Snohomish Health District	3020 Rucker Avenue, #200 Everett, Washington 98201	(425) 339-5240 ◆ FAX (425) 339-5255
Southwest Washington Health District ***(Clark and Skamania Counties)***	Post Office Box 1870 (2000 Fort Vancouver Way, Zip 98663) Vancouver, Washington 98668	(360) 397-8472 ◆ FAX (360) 397-8424
Spokane Regional Health District	West 1101 College Avenue Spokane, Washington 99201	(509) 324-1697 ◆ FAX (509) 324-1699
Tacoma-Pierce County Health Department	3629 South "D" Street, MS 092 Tacoma, Washington 98408 Mary Bridge Children's Health Center 311 South "L" Street Tacoma, Washington 98415	(253) 798-6517 ◆ FAX (253) 798-4787 (253) 403-4799 ◆ FAX (253) 403-1540
Thurston County Health Department	529 West Fourth Street (MS: 0947) Olympia, Washington 98501	(360) 754-3351 ◆ FAX (360) 786-5594
Wahkiakum County Health Department	Post Office Box 696 (64 Main Street) Cathlament, Washington 98612	(360) 795-6207 ◆ FAX (360) 795-6143
Walla Walla County-City Health Department	Post Office Box 1753 (310 West Poplar) Walla Walla, Washington 99362-0346	(509) 527-3290 ◆ FAX (509) 527-3264
Whatcom County Health Department	Post Office Box 935 (1500 N. State Street) Bellingham, Washington 98227	(360) 738-2522 ◆ FAX (360) 676-6729
Whitman County Health Department	Public Services Building North 310 Main Street Colfax, Washington 99111	(509) 397-6280 (Colfax) (509) 332-6752 (Pullman) ◆ FAX (509) 397-6239:
Children's Village - Yakima	3801 Kern Road Yakima, Washington 98902	(509) 574-3260 ◆ FAX (509) 574-3210

** Indicates Regional Representative

◆ FAX or Internet not located in agency office.

How to complete the HCFA-1500 claim form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide. The numbered boxes on the claim form are referred to as fields. A number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be entered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field Description

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client. This informatio is obtained from the client's current monthly Medical Assistance IDentification (MAID) card and consists of:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

- **9a.** Enter the other insured's policy or group number *and* his/her Social Security Number.
- **9b.** Enter the other insured's date of birth.
- **9c.** Enter the other insured's employer's name or school name.
- **9d.** Enter the insurance plan insured's health maintenance organization, private supplementary insurance.

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payer of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the primary physician.

17a. **ID Number of Referring Physician**: When applicable, enter the 7-digit MAA-assigned primary physician number.

19. **Reserved for Local Use**: When applicable, enter:

- "B" - Baby on parent's PIC; or
- When billing for children, the EPA number or prior authorization number.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the claim number listed on the Remittance and Status Report.)

23. **Prior Authorization Number:** When applicable. Use the prior authorization number assigned to you if/when services have been denied and you are requesting an exception to policy.

For children: The CSHCN coordinator's stamp (shown below) and signature must be indicated here. **The EPA number or prior authorization number must be entered into field 19.**

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., September 4, 2000 = 090400).

24B. **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

Code	To Be Used For
3	Office/Ambulatory Surg Ctr
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)

24C. **Type of Service**: Required. Enter a **9** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

Modifier: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM current volume.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. **Do not include dollar signs or decimals in this field**. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading Patient Account Number.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code And Phone #**: Required. Put the *Name, Address,* and *Telephone #* on all claim forms.

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, etc.). When a valid group number is entered in this field, payment will be made under this number.

Sample Claim Form to be inserted before publishing.

Sample Claim Form to be inserted before publishing.

EPA Sample

This is a blank page.